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ABSTRACT

This handbook presents the essential components of a comprehensive family service system for low-income families. It shows, through the documentation and description of two low-income African American communities over 4 years of development work, the types of information that should be collected about community functioning so that informed decisions can be made. It also lists key components of comprehensive family service systems, and makes recommendations for systems development based on the key belief that service systems should be oriented toward developing support structures that empower individuals and families to become confident and competent, and enable them to seek and receive needed services. Section I of the handbook describes the communities in which the development work took place: San Francisco (California) and Marin City (California). Section II lists the four major components of an effective comprehensive family service system: a health system, a social services system, a housing system, and an education system. In addition to the four systems, a coalition strategy must also be developed to link the key systems. This section offers a description of each component, their major elements, and recommendations for implementation. (Contains 29 references) (JB)

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Comprehensive Family Service Systems

A Handbook for Planning and Practice

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Comprehensive Family Service System

A Handbook for Planning and Practice

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November 1992

ABSTRACT

This handbook presents the essential components of a comprehensive family service system for low-income families. It is written as a guide to organizations and individuals having an interest in planning, developing, or studying comprehensive family service systems. It shows, through the description of two low-income communities, the types of information that should be collected about community functioning so that informed decisions can be made. It also lists key components of comprehensive family service systems, and makes recommendations for systems development.

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INTRODUCTION

This handbook is based on four years of development work in two low-income mostly African-American communities. It describes what we at Far West Laboratory have come to believe are the essential components of a Comprehensive Family Service System. Briefly stated, comprehensive service systems for low-income families and children should be oriented toward developing support structures that empower individuals and families to become confident and competent, and enable them to seek and receive needed services. Individual, family and community problems need to be identified, needed resources developed and interventions made at the community level. Community institutions need to be influenced to change in ways that strengthens problem solving capacity; that are culturally relevant and reflective of community needs. These activities should be performed in collaboration with professionals from many disciplines including education, social work, public health, community mental health, child development, child care, public administration, city planning, employment, business, economic development, housing, criminal justice, as well as by informal helpers, voluntary associations and political action groups all working within a coordinated system.

Generalizations made from the recommendations we will put forward should be informed by the context in which our development work took place. Therefore descriptions of the communities, family living conditions, and service climates are provided. It is our strongly held opinion that there is no one right model for serving families and that systems designed for this purpose must be attuned to and driven by each individual communities characteristics. Never-the-less, it is hoped that the information presented based on our experiences will help those engaged in planning and implementing family focused community interventions to develop relevant and effective systems.

Part I of the hand book describes the communities in which the development work took place and should be used as an example of some of the common information about communities that needs to be identified for effective system development. Part II lists the necessary components of an effective comprehensive family service system.

SECTION ONE: DOCUMENTING THE COMMUNITIES, FAMILY CONDITIONS, AND SERVICE CLIMATES

In communities where the need is most apparent for the development of comprehensive family services systems there is found a significant population of disadvantaged individuals and families who lack the basic resources or conditions believed to be necessary for an equal position in society, such as adequate housing, access to health and mental health services, adequate employment and educational opportunities. "Included in this group are individuals who lack training and skills and either experience long-term unemployment or are not members of the labor force, individuals who are isolated socially from mainstream patterns and norms of behavior,individuals who regularly abuse drugs and alcohol, parents who engage in activities that contributes to high incidence of child abuse and neglect, individuals involved in street crime and other forms of aberrant behavior, and families who experience long-term spells of poverty and/or welfare dependency. Furthermore, there is a significant number of families headed by mothers who tend to belong to racial minorities, were never married, and are high school dropouts (Wilson, 1987)." These socially impoverished communities are characterized as high-risk environments, where those who need the most tend to be clustered together in settings that must struggle most to meet those needs. The picture that emerges from the high-risk community is one of very needy families competing for scarce social resources (Garbarino, 1977). These generalized characteristics of the high-risk communities serves to illustrate its many causes, and to emphasize that no one agency or group will succeed in eliminating them without a comprehensive intervention modality. The San Francisco communities and Marin City, communities that we have studied which will be described below, to a greater or lesser degree reflect the characteristics of the high-risk community.

I: San Francisco

The San Francisco communities studied are identified as high risk environments for children and families. Over three years of community activity FWL witnessed how the rapidly growing numbers of immigrants, poor, disabled, needy and homeless children, adults and families have stretched public and private social services providers beyond their capacity to respond in an effective,

coordinated and sustained manner. Sharp cuts in government funding, rising housing costs, increased drug problems, and escalating rates of violent crime have contributed to the worsening condition of families at risk in San Francisco .

San Francisco, where the so-called fair-market rent for a two-bedroom apartment is $919, is about as unaffordable a locale as there is for an Aide to Families with Dependent Children (AFDC) family of three whose monthly grant is $663. Small wonder that the increasing cost of living has forced thousands of welfare recipients out of San Francisco proper and the six surrounding Bay Area counties into the more affordable rural parts of California (S.F. Examiner, 1992). The poor who are left in San Francisco, many too deeply mired in poverty to flee, produce these key statistics:

Poverty:

- Three out of five single parents and their families in San Francisco live below the poverty line.

- Child abuse continues to escalate. In the past year alone, 4,000 child abuse petitions were filed, making a 78 percent increase in the past five years.

- Of the 46 California counties for which data are available, San Francisco County ranks #46.

- The City has at least 8,000 homeless people.

Health:

- One in four San Franciscans is uninsured or under-insured. The number of children born without any health insurance whatsoever has increased by 300 percent over a four-year period.

- Only one in six pregnant women gets adequate prenatal care.

- One in four teenage girls (under age 20) will have a child, the highest in the six counties that comprise the Bay Area.

- 85 percent of the child abuse petitions filed in San Francisco are due to drug addiction (almost always crack/cocaine is part of the addiction pattern) of the mother.

- In 1990 one thousand drug exposed babies were born in San Francisco. It is estimated that these babies will cost the city $40,000 each before they reach kindergarten.

- Between 10 percent and 16 percent of the general population is physically or mentally disabled; that number is being swollen by the AIDS-HIV epidemic, children with birth defects and children born addicted to crack.

Nutrition:

- 1,500 women and children are fed each day in the soup lines of Glide Memorial Church and St. Anthony's Dining Room (both located in the Chinatown/Tenderloin target area).

- San Francisco County ranks #37 of the 38 California counties which data on low birth weight babies are available.

Education:

- Forty-two percent of public school children are educationally disadvantaged.

- San Francisco County ranks #52 of the 58 California counties for which data of 8th-grade test scores are available.

- One in three youths will drop out of school between Grade 9 and graduation.

Crime:

- San Francisco County ranks #52 of the 54 California counties for which data violent crimes are available.

- San Francisco County ranks #22 of the 24 California counties for which data on juveniles in jail are available.

- The number of youth arrested for drugs rose from ten in 1980 to over 900 in 1990. San Francisco has the highest arrest rate for drug violations in the state, four times in proportion to the population.

- More than 80 percent of the adult convicts were abused children.

Employment:

- One year in the 1970s, the now-defunct Comprehensive Employment Training Act provided $54 million to San Francisco. This year, the Private Industry Council which came into being under the Job Training Partnership Act (JTPA) of 1982, has just $10 million. Only $40,000 comes from corporations and private foundations.

- The JTPA serves only three percent of the tens of thousands of city residents who are impoverished and need work.

Child Care:

- There are fewer day care slots this year in San Francisco than there were two years ago. Yet 51 percent of all mothers with children under age one in San Francisco are employed. A study done by the San Francisco Child Care Council showed that if affordable day care were available, the share of mothers with children under age one who work would climb from 51 percent to 65 percent

- There are over 6000 children on day care waiting lists.

In summary, many families in San Francisco are functioning very poorly. A substantial number of the children are drug exposed during pregnancy, many are failing school, and many are involved in juvenile delinquency and substance abuse. Many of their parents are unemployed (higher than 30 percent in each of the seven targeted communities), abusing drugs themselves, and in need of education, job training, child care and affordable housing. At the same time the support to these families has declined. Overall, less than six percent of San Francisco's funding for children goes to primary prevention. The rest is spent after the problems occur. Without assistance for a continuum of prevention and early intervention services, these families have little hope of improving the quality of their lives.

Perhaps the biggest gap in service provision is to the ethnic minorities who now make up 52 percent of San Francisco's population. Underfunding, and language and cultural barriers make it difficult for current programs to respond to the needs of families, particularly among new immigrants and refugees from Asia and Latin America. Institutionalized cultural insensitivity, along with a lack of bilingual staff, and geographic isolation is common.

Service Climate

Unfortunately, in the San Francisco family service community, the formal (community services) and informal (personal-social networks) support systems need to be strengthened. There is both a paucity of services and a lack of interagency coordination in the targeted communities. The high level of positive response we have received in our efforts to identify agencies willing to collaborate in planning comprehensive intervention systems indicates a strong desire and need to upgrade and orchestrate service agency activities. The management and staff of the collaborating agencies clearly want to improve, expand and coordinate their services.

II: Marin City

Marin City is an isolated African-American community located in otherwise affluent Marin County. In a county with one of the highest average household incomes in the nation, 36 percent of households in Marin City have

incomes below the poverty line. It is estimated that 34 percent of adults are unemployed and that 36 percent of adults have not completed high school. As many as 50 percent of adults may be functionally illiterate, and one study indicated that about 41 percent of all residents lack the basic skills necessary for entry-level jobs. Approximately 75 percent of residents are African American, and almost two-thirds reside in public housing. Eighty-nine percent of families are headed by a single mother. Marin City has high rates of unemployment, particularly among young males; crime, much of which is drug-related; and teenage pregnancy. Marin City children today face circumstances that children of other times have not had to struggle with. Indeed, there has always been substance abuse, but the introduction of crack has taken it to an unprecedented level of danger and despair. Children must struggle with the reality of crack use surrounding them, while they are increasingly expected to fend for themselves in a fast-moving society which no longer values extended family. The urgency of their situation is heightened by the fact that they still experience racism despite their parents' and grandparents' struggles and hopes.

The geographical layout of Marin City serves to weaken an already fragile community. In the late 1950s, the commercial center of Marin City was destroyed as part of a redevelopment project, and was never rebuilt. As a result of the same redevelopment action, a 32 acre piece of barren land separates the public housing in a valley called the "Bowl" from the hill where the ownership portion of the community is located. Approximately 1/3 of the Marin City population lives in the public housing projects. The Bowl Area housing pattern consists of Public Family Housing, Limited Equity Cooperative Housing, and Single Family Housing. As of 1987, there were 292 contiguous low-rise and mid-rise public housing units, 98 units of cooperative housing, and 86 single family homes. The average household income in the public housing units is $8,000, and the monthly rent per unit is approximately $200/month.

Service Climate

Much of the social service support for the community comes from outside Marin City with agencies providing services based on categorical funding. One internal service agency is OGAD (Operation Give A Damn). This local agency often finds itself surprised by initiatives introduced by outside agencies that have

been targeted to serve Marin City residents. OGAD administrators site this outside planning, fragmentation of services, lack of coordination and lack of direct funding of Marin City agencies as major frustrations.

Agencies tend to operate independently and not consider the impact of their services in relation to other services clients may be receiving from different agencies. There are some exceptions but these efforts at integration and coordination are limited.

There are six agencies that are attempting to integrate services for Marin City families through a case management approach. Of these only one has an established system of linking the program services across agencies and this organization is not yet serving families with children below school age. It is likely that there are many families with young children receiving overlapping case management services from more than one agency and yet there is insufficient orchestration of these services.

Family support services are part of each child care program but differ greatly in their intensity and ability to provide services to many families.

Some Marin City programs and agencies are overburdened with too many clients while others are under-utilized. For example:

The Marin City Public Health Nurse has a higher demand for services than she is able to supply. She has estimated that she could spend another day (in addition to the three days weekly) providing home visits to Marin City families in need.

OGAD's Family Preservation program is limited to only five families who receive intensive services. Other families in need of such intervention cannot be given needed services at this time.

Step II, the teen parenting program, currently serves 25 Marin City youth but in the past has provided educational services to almost twice that many. Staff there have to select the 25 to be served and report that there are many more with a need for such services.

Marin City Drug and Alcohol Outpatient Program is the only provider of recovery services physically located in Marin City. It is staffed by one treatment provider who provides community education and prevention in addition to chemical dependency assessments and counseling. (These limitations result in a gap in services; there is no comprehensive substance abuse treatment program available in Marin City).

All the child care programs, with the exception of Head Start, are full and have waiting lists. In contrast, Head Start has not had full enrollment and may have to close its Marin City classroom. In addition to Head Start, under-utilized services include: the Boys and girls Clubs of Southern Marin which offers recreation activities to the Marin City community; and the Marin Community Clinic which provides general medical services on a limited schedule which was recently further reduced because of lack of utilization.

Many county-based programs serve the Marin City community through outreach efforts which are often ineffective in attracting Marin City residents.

The two major providers of chemical dependency recovery services in the county, Centerpoint and Marin Treatment Center, have had limited success in providing treatment services to Marin City residents participating in the various programs there. Marin Treatment Center staff estimates that about 10 percent or less of their clientele is from Marin City.

Although there are many programs available they are not coordinated and this no doubt results in clients receiving fragmented rather than cohesive services. It was not possible to determine which Marin City families were found in the caseloads of multiple agencies and receiving services that were overlapping and not integrated. Also programs that attempt to reach Marin City families through outreach efforts may not succeed in attracting potential clients to their programs located elsewhere in the county despite Marin City families' need for such programs and the programs' caliber. Agencies involved in Marin City should be collaborating and linking their services with a long-term focus upon and commitment to the families that are served rather than specific agency services or particular family member clients.

III. Documentation Strategy

In addition to documenting community functioning, the documentation of program efforts is also an integral part of a comprehensive family service system. The documentation of the attainment of a comprehensive family service system's goals, objectives and methodology in quantifiable terms requires a data collection system, technical assistance, formative feedback and the study of the development and effectiveness of each component (Izu, 1992). The program documentation recommend consist of — but is not limited to — the following components(HHS 1992):

A. **Process Documentation**: should be adequate in the collection of quantitative and qualitative data to permit a detailed description of the implementation of the project; it should describe what conditions existed prior to program start up; and provide a useful description of who worked with whom, when, how often, in what settings and what were the results of those activities.

B. **The Outcome Documentation**: should adequately assess whether the program was effective in meeting its goals and to what extent these can be attributed to program efforts and activities as they relate to changes in community and agency policies and practices (intermediate) and changes in knowledge, attitudes, and behavior (longitudinal).

C. **Sustainability**: documentation should provide information on factors which facilitate or inhibit the development and sustainability of the comprehensive system.

D. **Sub-studies of Project Components**: documentation should identify and collect information about the various project components.

SECTION II: BASIC COMPONENTS OF COMPREHENSIVE FAMILY SERVICE SYSTEMS

Not withstanding its multifarious nature, a comprehensive family service system contains four major service components: health, social services, housing, and education. Within each of these categories are relevant subsets or elements. The *health system* delivers medical services, including prenatal, infant care and development programs, nutrition, and mental health services, including alcohol/drug abuse treatment and prevention. The *social services* system includes child welfare, day care, counseling, income maintenance, employment development, training, juvenile and criminal justice, emergency and disaster relief programs. Ancillary elements include recreation, advocacy and legal services. *Housing* includes market-rate, subsidized: HUD Section 8, public housing and homeless housing programs. The *education system* provides primary instructional services to children in public and private schools. Preschools, e.g., Head Start and other early childhood education programs; early intervention child care programs and parent education may be included in this category.

In addition to the four systems a *coalition strategy* must also be developed to link the key systems. Following is a description of each component, their major elements and recommendations for implementation:

A. Health System

The differential effectiveness of the health care delivery system for whites and minorities begins with prenatal care. From birth to death, the poor experience higher susceptibility to chronic diseases and health hazards than is generally true for nonminorities. Also, the relationship between socioeconomic status and health is strong, and most studies detail its existence over many measures of health status. According to Bunker and Gomby (1989), researchers have yet to reach a consensus to explain the effects of socioeconomic status on health status. They see the following as possible explanations:

1. The poor have fewer resources, both financial and psychological, with which to respond to life events.

2. Parental nurture plays an important mediating role in creating health and good behaviors, and families with higher incomes and/or educational levels may be better situated than poor families to provide the nurturance that leads to good health behavior.

3. The greater access to medical care that upper socioeconomic individuals might be expected to enjoy may help to promote health and prevent disease.

4. Low socioeconomic individuals may have poor self-esteem, a low sense of self-efficacy, or they may be unwilling to defer personal gratification to the same extent as higher socioeconomic individuals. These psychological differences may lead to differences between high and low socioeconomic individuals in the types of health behaviors in which they engage.

5. Finally low socioeconomic individuals may practice different, and less healthful behaviors than high socioeconomic individuals.

The following describes major elements of the health system:

1. **Health Care**: an effective health care program ensures that each individual and family receives health screening and assessment, immunization, treatment and referral, dental, nutritional, and mental health services within an ongoing, coordinated system of care which will promote prevention, early intervention and remediation of specific health problems.

2. **Prenatal Care**: is the most fundamental point of entry for interventions with high risk families with children in the crucially formative first few years of life. The essential components of prenatal care are medical care, health education, and social support services. Good prenatal care dramatically improves the chances that a woman will bear a healthy baby. Mothers who do not have access to it suffer higher rates of infant mortality or may give birth to premature or low-birth-weight babies (Hamburg, 1991).

3. **Infant/Toddler/Family Development**: the number and variety of disciplines and practice specialties that are concerned with infants, toddlers and their families are impressive. To understand its importance and scope within an integrated services system we must think in terms of "domains of concern." A domain of concern is an area on which attention and effort are focused. The possible universe of domains of concern can be divided into: a) the child; b) the parent; c) the parent-infant relationship; d) the child's family and; e) the community (National Center for Clinical Infant Program, 1990). Consequently, a holistic approach to child and family development is recommended, including day care and early childhood development, health screening, and nutrition services for infants and toddlers; parenting training, mental health services, including individual, family and group treatment for parents and families; identification of appropriate community resources (health, education, employment, housing), advocacy and referral.

4. **Nutrition**: the underlying premises guiding nutrition programs is that it must be holistic, i.e., designed not only to address the nutritional needs of children, but also to influence the nutritional practices of the entire family.

   Nutrition programs should be sensitive to the influences that affect behaviors in regard to food. Programs should recognize and understand unfamiliar values, practices, feelings and preferences. Parents and other family members should be seen as meaningful resources to bring about this type of understanding. 3 Cultural factors, economic factors, and individual differences are valued and considered. Food services programs should meet the federal Child Care Food Program guidelines requiring balanced meals, and standards that address age appropriate and special needs of children. Emergency food resources should be identified and families trained to access those resources when needed.

5. **Mental Health**: the goals of primary prevention is to promote social and functional competence, coping capacities, ego strengths, and "positive mental health." A key factor is the identification of individual

and community strengths, rather than deficits or weaknesses. The strategies indicated for approaching the goals are two fold: a) strengthen individual capacities and/or decrease individual vulnerabilities and; b) through planned social change, modify environmental conditions that frustrate and prevent positive mental health.

Mental health services should be directed at seven target groups (San Francisco Department of Public Health, 1990):

A. **Child and Family**: the highest priority is given to the most severely disturbed children: those in need of public services and supports from several agencies.

B. **Adult**: the priority is given to (1) those meeting involuntary treatment criteria; (2) severely mentally ill and their families or social support groups; (3) mentally ill referred or diverted from county jails; and (4) those in emotional crisis or at risk of developing mental illness.

C. **Geriatric**: priority for access to services is given to (1) those meeting involuntary detention criteria and potentially in need of hospital care; (2) the severely mentally ill and their families or social support groups; and (3) those in emotional crisis or at risk of developing mental illness.

D. **Substance Abuse**: provides services for adults, adolescents and children who need drug or alcohol treatment or prevention education.

   Due to its serious nature, wide spread manifestation and impact on families, substance abuse service is more extensively explored below.

E. **Forensic Services**: all jail inmates have a constitutional right to medical services, including psychiatric care. Since the majority of prisoners come from low-income communities similar to those we have described, recognizing that they will ultimately return to those

communities, we recommend planning for their inclusion the comprehensive family service system as well. This should occur at the beginning of their imprisonment but certainly prior to parole.

F. **Forensically-linked Victim and Offender Services**: county governments provide certain services to victims of sexual assault and abuse. Offenders, because so many who use violence against other were victims of violence themselves, are provided certain services.

G. **Special Needs Groups**: in addition to mentally ill offenders, the following groups are within the populations of the mentally ill, substance abusers, and individuals involved with the criminal justice system whose needs require a specialized response: (1) ethnic groups, (2) mentally ill substance abusers, (3) the homeless mentally ill, (4) women, (5) sexual minorities, (6) persons with HIV infection, (7) the developmentally disabled, and (8) the physically disabled.

6. **Drug Abuse Prevention/Treatment**: a substance abuse prevention and treatment service plan is an integral component of the overall case management plan for each individual and family. Understanding the impact of drug-related activities on children, families and community is essential in the design of effective service plans. The service plan includes assessment, identification of problem areas and the development of practical strategies for intervention. Following are some of the key findings and recommendations by the California State Social Services Advisory Board (1991) that should be considered in the development a substance abuse prevention plan:

A. Key Findings:

1. The impact of the drug abuse epidemic has been most noticeable on health, child welfare, and criminal justice systems.

2. Substance abusing families must be treated as a family unit whenever possible, rather than receiving individual treatment.

3. Separating family members may be detrimental to the recovery of the substance abuser, impede development of parent- child attachment.

4. Services and treatment programs physically located in different geographic areas create difficulty of access for the recovering addict and his/her family.

5. The programs that are most successful include a high degree of community and interagency cooperation and support.

6. Traditionally, programs have focused primarily on the substance abusing male. There are limited programs available for substance abusing pregnant women. There are few residential treatment programs for addicted mothers and their children.

7. Substance abuse can be viewed from a number of perspectives, including criminal justice and social service. Substance abuse is not only a legal and social problem, but is also a medical condition requiring treatment. Societal response to this problem must incorporate this understanding.

8. Prevention and early intervention programs show positive results and communities critically need them to reverse the escalating incidence of damage to children from substance abusing families. Efforts to prevent or intervene with pregnant and parenting substance abusers at the earliest possible time are critical to the long-term effectiveness of services and treatment.

B. Key Recommendations:

1. Federal, state and local governments should support the design and funding of programs that meet the needs of the substance abusing family as a unit and keep the family intact whenever possible. The critical role that spouses/significant others play in substance abuse and pregnancy should be recognized.

2. Service providers should coordinate and consolidate model programs to help multi-problem families. Integration of multi-disciplinary services will allow for the development of more individualized treatment plans to meet specific family needs.

3. Case management (including follow-up, outreach, and tracking) and direct services (such as in-home services, child care for siblings, transportation) are essential in assisting high risk families to access needed services for their treatment and recovery.

4. Substance abuse prevention program should be incorporated into school programs, jails, juvenile detention facilities, and other institutions involving high risk populations.

5. More programs that address the special needs of substance abusing women who are pregnant or parenting should be developed.

B. Social Services Systems

Social services systems consist of both public and private entities organized to respond to the needs of individuals and/or families who are in distress. Social services systems also represent a duality: the care and rehabilitation of troubled individuals or families and the elimination of social conditions which bring on hardship, that is to say, treatment and reform. These approaches may be viewed as complementary rather than conflictual and are aimed at a single purpose — the well-being of the individual. Social work, the discipline that delineates the professional services, methods and activities of social services systems, is confronted by the dilemma of whether the intervention should stress the delivery of services to individuals in need or the modification of social conditions which predispose some people to dysfunction or disadvantage (Cox, Erlich, Rothman, Tropman, et al, 1970). These two aspects of social work represent a coordinated approach to the solution of these dualities: practice and policy, psychological individualization and social reform, improvement of the individualized services and improvement of social conditions, direct rendering of services and broader programs of prevention, personal therapy and social leadership (Cox and Garvin,1970). The major elements of a social services system are briefly described:

1. **Community Needs Assessment**: of particular importance is baseline information about the community to be served. According to Warren (1975), the five major functions of community are (a) production-distribution- consumption; (b) socialization: the transmission of prevailing knowledge of social values and behavior patterns to individual members; (c) social control: the influence of behavior of community members toward conformity with community norms; (d) social participation: opportunity for social interaction frequently through church, business, voluntary work, public health and welfare agencies, and personal social networks); and (e) mutual support-responsiveness to physical or psychosocial needs of community members, especially in times of crises. Documentation of the quality and quantity of these functions will prove helpful in determining the degree of community competence which is described as a culture or climate and a set of processes which are either facilitative or destructive of individual and collective functioning (Iscoe, 1974). The collection of the following information related to community competence will help greatly in the design of an effective comprehensive family services system:

   Birth Rate
   Infant Mortality Rate
   Ethnic Diversity
   Children Population By Age/Ethnicity
   Number of Low Birth Weight Babies
   Teen Births
   Incidence of Sexually Transmitted Disease
   Utilization of Prenatal Care
   Child Abuse and Neglect Statistics
   Number of Families Receiving AFDC Benefits
   Employment Statistics
   Utilization of Mental Health Services
   Substance Abuse Statistics
   Juvenile and Adult Crime Statistics
   School Dropout Rates
   Housing Stock
   Utilization of Health Care Services

2. **Recruitment Planning**: assures that the most needy families of the target group will be served and that some will have handicapping conditions. Recruitment staff should be carefully trained to talk with families sensitively and to make group presentations to local groups to explain the services of the program. Basic elements of the recruitment strategies includes the following:

   A. Contacting families through family-oriented organizations, e.g., churches, schools, parent groups.

   B. Reaching families through family service agencies, e.g., local health centers, prenatal clinics in neighborhood and hospital serving areas, and high-risk interagency councils.

   C. Using direct outreach, e.g., setting up stations at local grocery shopping centers, distributing handbills, and posting information in store front windows, etc.

   D. Obtaining referrals from counseling services within the local neighborhood, e.g., drug counseling programs, child protective services, etc.

Fliers and posters should be distributed to as many target area family-focused organizations as possible. The fliers and posters should be multilingual and indicate the locations, dates and times for sign up. The fliers and posters should indicate the types of information that families need to bring to sign up for participation, e.g., birth certification and family income verification information. Efforts should be made to provide multilingual media announcements through a variety of vehicles, e.g., radio stations, television, neighborhood newspapers. Efforts should be made to provide a translator when needed to recruit families and serve on outreach teams.

3. **Case Management**: assigns primary responsibility for helping children and families to access appropriate services to either an individual or an interagency team which establishes a systematic, continuous process in which the child and family are actively involved

in planning the steps they can take to improve their lives and in evaluating the results. The general activities includes:

A. Assessment: ongoing identification of the child and family's strengths, problems, and needs.

B. Planning: development of individualized and family case management plan to address service needs and objectives.

C. Linkage: referring and assisting family to access required services.

D. Monitoring: reviewing the child and family's progress and the appropriateness of service modalities.

E. Advocacy: interceding on behalf of clients for more responsive policy, procedures and to obtain needed services.

4. **Child Welfare**: is a major aspect of the social welfare systems that concentrates on children from families who "get into trouble" and what happens to these children who are officially called abused, neglected, dependent, or delinquent. Since many of these children come from poor families, a concern for the welfare of these families is demonstrated in the payment of funds under the Aid to Families with Dependent Children provision under the Social Security Act (Bush, 1988). Child protective services, foster care and adoptions are important components of the child welfare system.

5. Child Day Care: child day care plays an important role in identifying and reporting child abuse, because it provides the opportunity to observe children in a wide variety of settings during the year, including play behavior and parent-child interactions. Child care plays a role in child abuse prevention by physically separating the child from the stress setting by: (1) giving parents a daily respite and the time for counseling and other social services; (2) giving parents the opportunity for frequent normal discourse about child rearing; and (3) providing the protection of a daily "check," and appropriate developmental programs. Child care

and development programs either provide or connect abusive and at-risk families to many needed services, including parent education programs, drug and alcohol treatment programs, employment, training programs and counseling. One of the most important findings from research is that children who have benefitted most from being placed in child care centers are those who come from relatively poor families. Lally and Mangione (1989), at the ten-year follow-up of the Syracuse University early intervention study, reported that when program parents were asked what was best about the program, 79 percent responded by saying high quality child care.

6. **Income Maintenance**: provides support to needy individuals in the form of General Assistant payments and/or food stamps, and vouchers for temporary housing. Work incentive or "Workfare" type programs which transition AFDC recipients into employment in the private sector, is a prominent aspect of income maintenance programs. Usually payments for child care and training is included in Workfare programs. Child support payments by absent parents may also be included as a source of funds for income maintenance for welfare recipients.

7. **Employment Development/Training**: Social scientists have documented the serious consequences of unemployment for individuals, families, and communities, including increased rates of physical and mental illness, alcohol and substance abuse, marital discord, and family violence (Donovan, Jaffe, Pirie, 1987). To emphasize the importance of this element in a comprehensive family service program, we include below a detailed employment development and training program which includes job readiness training, basic aptitude improvement, centralized employer outreach, self-contained employer outreach and job retention support. In our example, which comes from work developed by San Francisco Renaissance Technical Training Institute (1992), the following assumptions were made as the basis for the establishment of relationships with families:

   - Most of the clients are employable;

- That Job Readiness Training (How to look for a job) is a major deficit and needs to be addressed;

- Some entry level positions can be identified that do not require the traditional 10 week skills specific training associated with JTPA-type programs;

- The employer will provide the training necessary to perform the required task;

- Employers need to be assisted to tap into a non-traditional labor pool;

- A greater effort needs to be made to encourage potential employers to hire clients via community-based networks of referrals.

Training sessions are being designed to make "job-ready" those persons who desire entry level employment but who lack the requisite job search capabilities.

An example of a training session organized into six major labor market oriented categories is:

A. How to Correctly Complete an Employment Application

- Job history
- Educational background
- Essay writing

B. Interview Techniques

- Videotape of mock interview (before and after)
- Role playing
- Questionnaires
- Body Language/eye contact
- Use of standard English

C. Appropriate Grooming

- Business attire
- Jewelry Accessories
- Hairstyles
- Color schemes

D. How to Find, Choose, and Secure a Job

- Want-ad research
- Use of Employment Development Department and other employment resource centers
- Union hiring halls
- Cold calling
- Walk-in approach

E. Career Beliefs Inventory/Skills Inventory

- Indoor/outdoor work
- Skills transference
- Public contact
- Learning styles awareness questionnaire

F. Resume development

- Structuring
- Tailoring for a particular job

It is anticipated that some employers will require a basic aptitude skill level. This level can be measured by a basic aptitude test given by the company or determined by other demonstrated proof (i.e. G.E.D. certificate).

Centralize Employer Outreach

Employer outreach should include, but not exclusively:

- Fast food companies
- Multiplex theaters
- Hospitality industry
- Personnel agencies
- Supermarkets
- Health care facilities
- Chain store pharmacies
- City-funded contractors
- Public utilities
- Airline industry
- Financial institutions
- New businesses
- Relocating businesses (where there is no negotiated exclusive arrangement)

Job Search Placement Referral

The goal should be that the final outcome for a client/participant is employment in an un-subsidized job. The programmatic flow is as follows:

A. Recruitment/Outreach

B. Pre-Orientation Assessment

C. Training Sessions

- Interview Techniques
- Completing Applications Correctly
- Appropriate Grooming
- How to Find, Choose and Secure a Job
- Career Beliefs Inventory
- Resume Writing

D. Referral to Jobs Bank

E. Matching Applicant to Potential Employer

F. Interview Scheduling

G. Interview Follow-up

H. Repeat process, as needed

Job Retention Support

Most workers lose their jobs due to behavioral problems during the probationary period. Job retention services are designed to assist the client/ participant to become a permanent company employee. Retention services should be available following placement for a maximum of six months, and should include:

A. Liaison with job supervisor

B. Personal finance assistance

C. Substance abuse prevention

D. Work place expectations

- Punctuality
- Productivity
- Good inter-personnel communication
- Following directions
- Employee/employer rights and responsibilities

E. Locating Childcare Support services

- Subsidized childcare facilities
- Arranging other subsidies

F. Career advancement advice

G. Continuing education guidance

H. Group and individual retention counseling sessions

I. Saturday sessions, unless otherwise scheduled

J. Forty sessions yearly

8. **Crime and Violence**: in poor communities crime and violence has created extremely high levels of distress for young children. Developing cooperative strategies with law enforcement agencies, service providers and families to empower communities becomes the central focus of an effective crime and violence prevention program. In a recent review of early intervention programs that were later found to prevent delinquency, Zigler, Taussig and Black (1992) state: " These programs, although by no means standard in purpose and methodology, were never initiated to reduce delinquency but rather to prevent school failure among at-risk populations." Ohlin (see Holt and Miller, 1972) developed an index of family interest while in prison to capitalize on the belief of many parole agents that parolees with closer family ties tended to do better. He found that 71 percent of the "active family interest" group were successful on parole compared to only 34 percent for those without contact.

9. **Ancillary Services**: includes services that primarily give support to these components. These services emphasize themes such as democratic procedures, voluntary cooperation, self-help, the education and development of indigenous leadership, advocacy, legal services, transportation and recreation.

C. Housing Systems

The differential effectiveness of social systems is nowhere more apparent than in housing. Evidence is convincing and readily available regarding the inequities in housing for low income families and communities. Both rental and owner-occupied housing stock available to the poor and minorities is consistently older, range from fair to poor in condition and is more densely inhabited. This contributes to conditions that leads to rodent and roach infestation, potentially

exposes children to high concentrations of lead which create health problems that may impair the ability to learn. Discriminatory real estate practices, resistance to the location of low income housing in middle class and affluent neighborhoods, the redlining of poor neighborhoods, especially minority neighborhoods, have conspired to reduce the flexibility of low income families to seek housing better suited to their needs. This contributes to a more rapid deterioration of older and poorer neighborhoods because funds for necessary home improvement are not available from financial institutions (Barbarin, 1980). A brief description of the major housing programs for low-income or poor families are as follows:

1. **Public Housing**: commonly called "projects," describes housing for eligible low-income families, senior citizens and the disabled. Priority is given to persons who are homeless, those who lost heir homes to natural disaster, victims of domestic violence, people who live in over-crowded or substandard housing, or those who pay more than half their income toward rent. In general to be eligible for public housing, singles cannot earn more than $27,000 a year and a family of two can have a yearly income no greater than $30,900. The cap for a three-member family is $34,750 a year and $38,600 annually for four people. Public housing is built by the federal government under the Department of Housing and Urban Development (HUD) but is managed and administered by local housing authorities.

2. **Section 8 Housing**: describes housing that is either built through HUD funding and managed by private concerns or subsidized by HUD in the form of vouchers which enable eligible low-income recipients to "afford" the market-rate monthly rental costs.

3. **Homeless Housing**: generally describes temporary, one room residential hotels or previously unused commercial buildings converted into dormitory-type facilities. Homeless housing is usually funded by local governments. The focus on homelessness should be on the necessary rather than the sufficient conditions. The development of comprehensive family service systems will defuse the sufficient conditions for homelessness by creating a support network that will

enable each individual to be maintained in an adequate living environment regardless of their economic or affective status.

D. Education System:

Traditionally, education has been viewed as the means of escape from poverty and disadvantage. Yet, today, when a high school education is barely sufficient to secure work that can provide economic stability, one of every four youngsters entering ninth grade will not graduate. In urban areas of concentrated poverty, the outlook is even more dismal. Research increasingly points to a demonstrable and fundamental troubling correlation between low educational achievement and serious problems outside the classroom (Levy & Shepardson 1992). The longitudinal findings of early intervention projects undertaken in the 1960s and 1970s with families from minority populations who were characterized as "high risk," showed that children exhibited fewer signs of failure in school than their controls. Another discovery was that attention to parent/child and caregiver/child relationships resulted in an increase in prosocial orientation by the child in later years. Also program children exhibited fewer and less severe encounters with the criminal justice system than their controls (Lazar and Darlington, 1982; Provence and Naylor, 1983; Lally, Mangione and Honig, 1986; Schweinhart and Weikart, 1980).

In addition, Lally (1992) pointed out the almost universal agreement among the scientists who participated in the early studies that: (1) an "inoculation" approach to family support (early intervention followed by a complete cessation of services) was less helpful to the families and children than continued but less intensive supports (Zigler and Valentine, 1979). Failure to benefit from early educational experiences has consequences later in life...(for minority communities and society as a whole), as reflected in the under representation of minorities in higher education and in the professions (Barbarin 1981). Following are some of the major elements of an educational program for a comprehensive family services system:

1. **Early Childhood Education**: the essential components are staff with specific training in early childhood development and education and a knowledge of preschoolers' needs; adequate resources to provide the

necessary services; group sizes that are appropriate to a classroom or a child care center. Programs should emphasize the development of cognitive skills, learning to learn skills and the acquisition of life skills.

2. **Parenting Education**: to enable parents and other adults in the household to provide sensitive and responsive care to their children. The program should teach parents about the developmental, health and nutritional needs of their children and how to create a home environment facilitative of their children's development.

3. **Development of Self-esteem**: parents and other caregivers should be encouraged to recognize each child's special qualities and respond positively to them. Consequently, learning environments should be created where cultural diversity, ethnicity, language, life style, gender, physical ability and resiliency are encouraged, promoted and respected.

4. **Transition Planning**: to maintain educational and developmental gains effective linkages must be achieved both horizontally: with other agencies, e.g., preschools (Head Start) with public schools and vertically: within other programs, e.g., infant/toddler day care with preschool.

5. **Staff Development**: ongoing training for staff is essential to meet the complex needs of multicultural, bilingual, and increasingly drug-plagued and violent communities where target families live.

6. **After School Programs**: should strike a balance between the tutorial and the recreational. These programs provide caregivers an excellent opportunity to teach skills that foster resiliency in children who are stressed due to exposure to violence.

7. **Fostering Resiliency**: studies have shown that while a certain percentage of high-risk children developed various problems, a greater percentage of the children became healthy, competent young adults. Childhood resiliency and vulnerability have specific relationships to the moral climate of families that build children's expectancies about the

nature of moral interchanges. Their family environment validates them as worthwhile human beings. Education should avoid the stereotype that children from stressful environment cannot succeed in the classroom (Western Center for Drug Free Schools).

E. Forming Coalitions

What we have learned from our experience in studying high-risk communities brings us into agreement with Melaville's and Blank's (1991) findings that a collaborative strategy is called for in localities such as these where there is a need to change fundamentally the way services are designed and delivered. A common collaborative strategy and one we recommend is the establishment of a coalition. A coalition can be arranged in a relatively short period of time. A coalition offers the advantage of increased influence among all groups represented and it tends to create egalitarianism among members as well. To organize a coalition, the following procedures are recommended:

1. A list of organizations that may seem appropriate for inclusion in the coalition is compiled. The local United Way is a good source to contact for a list of service organizations. Once a list is compiled each agency should be contacted by telephone to obtain a brochure or any written information about the organization's mission, service provision, resources and management personnel.

2. Each organization is assessed to determine its appropriateness for the coalition. A letter which briefly explains the purpose and goals of the coalition is forwarded to each potential member organization. The letter also includes a request for a meeting with the organization's chief operating officer (CEO) to discuss the matter in greater detail. Sensitivity to the quality and quantity of information that each agency CEO needs is required in order help the CEO to assess the impact of coalition membership on agency fiscal, programmatic and personnel policies. A list of potential member organizations should accompany the letter.

3. Due to the complex issues to be negotiated — including the memorandums of understanding — and the enormous amount of time

and effort this requires, coalition organizers should began six (6) months to one year in advance of any anticipated request for program start up. Organizers will need to prioritize their contacts with agencies and organizations according to the essential components we have described, the size and complexity of the organization and its decision-making structure. Bureaucratic organizations, therefore, should receive high priority because their complex administrative structure may require the approval of several department heads to effectuate a basic agreement. Community-based organizations, although less complex, often require the review and approval of their governing board before entering into an agreement.

4. The effectiveness of community coalitions can be rated by: 1) the degree to which the composition of coalition members is a logical choice based on (a) target population, (b) target risk factor(s) and (c) intervention(s) to be demonstrated and;(2) the adequacy of the description of the proposed coalition, documentation of endorsement by proposed coalition members and other organizations serving the target population, and the degree of commitment of each coalition member to the coalition and to the proposed implementation plan, including the amount or extent of support indicated by coalition members to cover a portion of project needs (HHS, 1992).

5. The memorandum of understanding (MOU) or letter of agreement is the document that formalizes the relationship between the coalition sponsor and each member organization.

6. The MOU briefly describes the member organization's mission statement, the services it provides, the specific role it will play or duties it will perform, the resources it will bring to the coalition, and time commitment.

7. Each component of the comprehensive family service system should be stated in very specific terms and the source for its provision should be clearly identified by a statement of commitment.

8. The MOU is recommended as the most effective device to formally document who (the organization), what (the activities), when (the time frame or duration), where (the locality) and the resources that each member organization will commit to the coalition. The MOU is a vital document to initially assess the strength and weaknesses of a coalition.

CONCLUSION

The major service systems — health, social services, housing, and education — represent the core services required in the development of a comprehensive family service system regardless of the model. These systems have been shown to be a necessary combination of services to have true and long lasting impact on low-income individuals, families and communities. The philosophy of service with which they are implemented is also crucial to the success of any comprehensive family service system. No matter what components are available if the support structures that are developed do not empower individuals and families to become confident and competent in the pursuit of their own goals the system will fail.

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